

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007565

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 49

FILED FEB 19 1963

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Caldwell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>1 Day</u>	c. CITY OR TOWN <u>Breckenridge</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Mabel</u>	Middle <u>Harper</u>	Last <u>Ralston</u>	4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> , Year <u>1963</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/93</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Avalon, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Jacob Harper</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Hoyt</u>	14. NAME OF HUSBAND OR WIFE <u>Willard Ralston</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date) <u>No</u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>Willard Ralston Breckenridge, Mo.</u>	Address <u> </u>
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18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypovolemic Shock</u> 8 hours
	DUE TO (c) <u>Perforated Intestine</u> 30 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the 'terminal' disease condition given in PART I (a) <u>Surgical intervention for resection of intestine</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from <u>2-14-63</u> to <u>2-15-63</u> and last saw her alive on <u>2-15-63</u> Death occurred at <u>3:55</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Shirley Wright Do</u> (Degree or title)	22b. ADDRESS <u>Breckenridge Mo</u>	22c. DATE SIGNED <u>2-16-63</u>
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23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	23b. DATE <u>2/15/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Breckenridge, Mo.</u> (State)
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24. FUNERAL DIRECTOR <u>Mead-Pitts</u> ADDRESS <u>Breckenridge, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 16, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

0595

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MAR 1 1963

Permit not obtained:
Revised to Mr. 2-15-63
Recd from Mr. 2-16-63
With duly signed 2-16-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John W. Little

Licensed Embalmer No. 5074

P. O. Address Beckwith, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above, constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.